AGENCY
ASSESSMENT OF PNEUMONIA RISK

Name: _____ Date: _____

Person/Title Completing Assessment:_____

Instructions: **Place a check mark in all areas that apply**

1. _____ 50 years old or older **AGE**:_____
2. _____ Hx. of one or more episodes of pneumonia in the last five years.
   Number of episodes _____ Dates: _____
3. _____Dysphagia diagnoses with pharyngeal phase symptoms
   (As documented on MBS or FEES)
4. _____Poor oral/dental status including signs of periodontal or gingival disorder, cavities or poor oral hygiene.
5. _____Dependent for oral care
6. _____Feeding modality
   a. _____Enteral feeding
   b. _____Eats by mouth and dependent for feeding for all or part of meal
7. _____Multiple medical diagnoses and/or multiple prescription medications
8. _____Requires a positioning program
9. _____Now or former smoking
10. _____Dry mouth or excess oral secretions
11. _____Diseases and conditions including GI, GERD, esophageal dysmotility, CHF, COPD, Asthma

Number of Items Checked (1-11):_____

Form should be completed by the client's IDT (Nurse, House Manager, Case Manager, etc..)
Once completed, original assessment kept on site with copy mailed or faxed to:

Southeastern Indiana Outreach Services
711 Green Road
Madison, IN 47250
Phone: 812-265-7493 Fax: 812-265-7444

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